Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WEST HOUSTON MEDICAL CENTER
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
#15

MFDR Tracking Number
M4-09-9432-01

MFDR Date Received
JUNE 15, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As required by law, the Provider billed its usual and customary charges for the services rendered in this claim…The claim presented by the Provider was billed in the same manner and at the same rates that it would bill any health plan, insurer, or other medical bill payor…it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case…"

Amount in Dispute: $21,738.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 2, 2009: "The medical bill in question was reimbursed pursuant to a private contractual fee arrangement. The bill was reduced using the ANSI code 45, and the Requestor admits to the contract...Requestor's fees were reduced as they did not provide invoices for the implantables…"

Respondent's Supplemental Position Summary Dated July 10, 2009: "The medical bill in question was reimbursed pursuant to a private contractual fee arrangement. The bill was reduced using the ANSI code 45, and the Requestor admits to the contract...Requestor stated that this medical bill was reduced pursuant to a Beech Street contract. However, that is incorrect. Pursuant to the attached information, this bill was reduced pursuant to a First Health contract…"

Respondent's Position Summary Dated October 27, 2010: "The medical bill in question was reimbursed pursuant to a private contractual fee arrangement. Enclosed please find an affidavit from the bill review audit company, Concentra, indicating that the bill was paid pursuant to a contract with First Health.

Responses Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2008 Through October 2, 2008	Inpatient Hospital Surgical Services	$21,738.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 10, 2008
   - 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - 649-006 — REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE WITH A SEPARATE ALLOWANCE FOR IMPLANTABLES.
   - 7 — The procedure/revenue code is inconsistent with the patient's gender.
   - B12 — Services not documented in patients' medical records. $0.00
   - W1 — Workers Compensation State Fee Schedule Adjustment $0.00

   Explanation of benefits dated December 12, 2008
   - 45 — Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - 7 — The procedure/revenue code is inconsistent with the patient's gender.
   - W1 — Workers Compensation State Fee Schedule Adjustment $0.00
   - W3 — Additional payment made on appeal/reconsideration.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier reduced disputed services with reason code "45- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 13, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the

manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

The division finds that the documentation submitted supports the facility requested separate reimbursement for the implantables. However, the cost invoices were not found to be certified in accordance with §134.404(g)(1); for this reason the MAR is calculated according to §134.404(f)(1)(A).

4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 460, and that the services were provided at West Houston Medical Center. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $24,297.89. This amount multiplied by 143% results in a MAR of $34,745.98.

The division concludes that the total allowable reimbursement for the services in dispute is $34,745.98. The respondent issued payment in the amount of $35,064.58. Based upon the documentation submitted, additional reimbursement is not is recommended.

Conclusion

Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 7, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.